EXHIBIT 7

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION
This authorization is intended to comply with the Health Insurance Portability and Accountability Act of 1996

Patient Name: W[redacted] W[redacted]

Previous Name: N/A

Date of Birth: [redacted]2017

Social Security Number:

AUTHORIZE DISCLOSURE FROM:

University of Utah Hospital &
Clinics / Burn Center
50 North Medical Drive
Salt Lake City, UT 84132

DISCLOSE PROTECTED HEALTH INFORMATION TO:

McCoy Leavitt Laskey LLC
N19 W24200 Riverwood Drive, Suite 125
Waukesha, WI 53188
&
Morgan & Morgan P.A
Attn: Rudwin Ayala
20 N. Orange Ave, Suite 1600
Orlando, FL 32801

To: Medical Records Custodian and all other doctors who may have treated or examined me, and any and all other institutions or hospitals where I may have been treated or examined:

I understand that if the person(s) and/or organization listed above are not health car providers, health plans, or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

You, and each of you, are hereby authorized to permit the law firm of McCoy Leavitt Laskey LLC and/or their agents or employees, to examine and make copies of ALL records, reports, information or opinions relative to my employment or to my physical condition concerning any care or treatment you may have given me in the past, present and beyond the date of the below signature, including your record for medical charges, billing, invoices, or financial arrangements made for these services.

I authorize you to permit them to examine, copy, or receive copies of any and all medical and/or hospital records, reports, photographs, x-rays, papers, writings and accounts concerning such care, treatment, physical condition or prior physical condition which may be in your custody or under your control.

THIS AUTHORIZATION REQUESTS THAT YOU PROVIDE MY ENTIRE RECORD AND DOES NOT AUTHORIZE YOU TO SEND SELECTED PORTIONS OF MY RECORD AT YOUR DISCRETION. I am aware of my rights under the Health Insurance Portability and Accountability Act of 1996 and I understand that the law is intended to protect the privacy of protected health information.

PURPOSE OF AUTHORIZATION: Oral consultations are permitted. This authorization is given for the purpose of assisting in collecting evidence in relation to my injuries and damages suffered in accident on February 1, 2022. This authorization is **not** limited to the date of loss forward, see correspondence for dates requested.

RIGHTS WITH RESPECT TO THIS AUTHORIZATION: Right to Inspect or Copy the Health Information to be used or disclosed-I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the health information department. Right to Receive Copy of this Authorization-I understand that if I agree to sign this authorization, which I am not required to do so, I must be provided with a signed copy of the form. Right to refuse to sign this authorization-I understand that I am under no obligation to sign this form and that the person(s) and or organizations(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. Right to Withdraw this Authorization-I understand that written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the health information department. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization. A PHOTOCOPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL.

EXPIRATION DATE: This Authorization is valid for one (1) year. I have had opportunity to review and understand the content of this authorization form. By signing this authorization I am confirming that is accurately reflects my wishes.

Subscribed and sworn to before me
This _____day of _____, 2023.

Please see attached Proof.com notarial certificate

_____
Notary Public, State of _____
My Commission expires: _____

Dated this 2nd day of January, 2024.

Stephanie Wadsworth
SIGNATURE
PRINTED NAME: Stephanie Wadsworth as Parent and Legal Guardian for Weston Wadsworth

JURAT

State/Commonwealthof TEXAS)
)
☐City ☑County of Harris)

On 01/02/2024 (*Date*), before me, Alexis Trice (*Notary Name*),
the foregoing instrument was subscribed and sworn (or affirmed) before me by:

Stephanie Wadsworth
(*Name of Affiant(s)*).

❑ Personally known to me **-- OR --**

❑ Proved to me on the basis of the oath of _____ (*Name of Credible Witness*) **-- OR --**

☑ Proved to me on the basis of satisfactory evidence: driver_license (*Type of ID Presented*)

NOTARY PUBLIC STATE OF TEXAS
Alexis Trice
ID NUMBER
133454288
COMMISSION EXPIRES
November 17, 2025

WITNESS my hand and official seal.

Notary Public Signature: Alexis Trice

Notary Name: Alexis Trice

Notary Commission Number: 133454288

Notary Commission Expires: 11/17/2025

Notarized online using audio-video communication

DESCRIPTION OF ATTACHED DOCUMENT

Title or Type of Document: AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Document Date: 01/02/2024

Number of Pages (including notarial certificate): 2